NAME/ADDRESS CHANGE FORM

Complete and Return this Form to the Following Address

Kentucky Board of Licensure for Occupational Therapy
PO Box 1360
Frankfort KY 40602

Type of Change

- ☐ **Name Change**
- ☐ **Address Change**

Please Complete the Following for Identification Purposes

Lic/Cert # **Social Security #** **Today's Date**

☐☐☐☐ ☐☐☐ - ☐☐ - ☐☐☐☐ ☐☐ - ☐☐ - ☐☐☐☐

Signature: _____

Name Change (only)

Last Name **First Name**

Middle Name

Address Change (only)

Last Name **First Name**

Middle Name

Street Address

PO Box # **Apt #**

City **State** **Zip Code**

County